Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) Health Care Provider ( ) Injured Employee ( ) Insurance Carrier

Requestor's Name and Address: The Clinic for Special Surgery 900 12th Ave. Fort Worth TX 76104	MDR Tracking No.: M4-03-5562-01 Claim No.: Injured Employee's Name:
Respondent's Name and Address: BOX#: 4 American Protection Ins.	Date of Injury: Employer's Name: Meristar Hotels & Resorts, Inc. Insurance Carrier's No.: 4650139689

PART II: REQUESTOR'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documents:
1. UB-92
2. EOB's
3. Table of Disputed Services
4. Operative Report
5. Requestor's Introductory Letter for MDR for inadequate payment

Position Summary: "…Carriers are obligated to pay The Clinic for Special Surgery's usual and customary fees for ambulatory surgical services. This letter attests that this bill is at our usual and customary fees. The…bill is based on itemization of charges, a mode of billing that has been the same since this ASC opened in 1998…and represents our usual and customary charges."

PART III: RESPONDENT'S PRINCIPLE DOCUMENTATION AND POSITION SUMMARY

Principle Documents: 1. Respondent's response.

Position Summary: "…In arriving at a 'fair and reasonable reimbursement,' in this case, the carrier has reviewed the Medical Fee Guidelines and applicable ground rules…The primary procedure, CPT Code 64450 falls into Grouper 1, or a medium intensity level in the carrier's methodology for a base reimbursement of $508.80 with a HCFA index of 0.9997 for the Fort Worth area…The carrier had inadvertently failed to make payment of the provider's charge within 60 days…thus the payment included $18.43 in interest with the payment..."

PART IV: SUMMARY OF DISPUTE AND FINDINGS

Date(s) of Service	CPT Code(s) or Description	Part V Reference	Additional Amount Due
4/24/02	Ambulatory Surgical Center Care	1	$0.00

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

1.) This dispute relates to services provided in an Ambulatory Surgical Center that are not covered under a fee guideline for this date of service. Accordingly, the reimbursement determined through this dispute resolution process must reflect a fair and reasonable rate as directed by Commission Rule 134.1. This case involves a factual dispute about what is a fair and reasonable reimbursement for the services provided.

After reviewing the documentation provided by both parties, it appears that neither the requestor nor the respondent provided convincing documentation that sufficiently discusses, demonstrates, and justifies that their purported amount is a fair and reasonable reimbursement

(Rule 133.307). The failure to provide persuasive information that supports their proposed amounts makes rendering a decision difficult. After reviewing the services, the charges, and both parties' positions, it is determined that no other payment is due.

During the rule development process for facility guidelines, the Commission had contracted with Ingenix, a professional firm specializing in actuarial and health care information services, in order to secure data and information on reimbursement ranges for these types of services. The results of this analysis resulted in a recommended range for reimbursement for workers' compensation services provided in these facilities. In addition, we received information from both ASCs and insurance carriers in the recent rule revision process. While not controlling, we considered this information in order to find data related to commercial market payments for these services. This information provides a very good benchmark for determining the "fair and reasonable" reimbursement amount for the services in dispute.

To determine the amount due for this particular dispute, staff compared the procedures in this case to the amounts that would be within the reimbursement range recommended by the Ingenix study (173.9% to 226.5% of Medicare for year 2002). Staff considered the other information submitted by the parties and the issues related to the specific procedures performed in this dispute. Based on this review, the original reimbursement on these services is within the lower end of the Ingenix range. According to the CMS ASC guidelines lab fees and diagnostic or therapeutic items or services are included in the facility fees and not payable. The decision for no additional reimbursement was then presented to a staff team with health care provider billing and insurance adjusting experience. This team considered the decision and discussed the facts of the individual case.

Based on the facts of this situation, the parties' positions, the Ingenix range for applicable procedures, and the consensus of other experienced staff members in Medical Review, we find that no additional reimbursement is due for these services.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES IMPACTING DECISION

28 Texas Administrative Code Sec. 134.1
28 Texas Administrative Code Sec. 133.307

PART VII: DIVISION DECISION

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is **not** entitled to additional reimbursement.

Findings & Decision by:

		9 / 23 / 05
Authorized Signature	Typed Name	Date of Decision

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. 413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision that is the subject of the appeal is final and appealable. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.